Personal, professional and interprofessional practice syndicate group reflective practice essay

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In this reflective assignment I will be exploring and discussing the professional, ethical and legal issues raised from a critical incident I have witnessed during clinical practice. It is hoped that through reflective learning I will be able to make sense of challenging situations experienced in practice in order to develop both my future practice as a registered nurse, and my own emotional intelligence. Rees, Monrouxe and McDonald (2015) have praised such methods of learning in a study which analysed student nurse experiences with professional dilemmas, concluding that narrating such experiences enables further development to cope with both previous and future incidents.

The purpose of this assignment is to reflect on my own professional practice and that of the healthcare professionals involved in the incident i have chosen to present. According to Schon (1983) there are two main parts to reflection, these are; reflection in action which occurs when the event is happening, and reflection on action, which occurs after the event has happened, this is where you can analyse the event and think about what could have been done differently. Reflection has great value as a learning tool, with many benefits including; promotion of deep thinking and learning from experiences, identifying strengths and weaknesses professionally and personally, an opportunity to understand beliefs, attitudes and values that may be different from your own, and ultimately to improve confidence both in yourself and the workplace (Davies, 2012).

The reflective model that I will be using in this assignment is Gibbs' Reflective Cycle (Gibbs, 1998) (See Appendix A). Developed by Professor Graham Gibbs in 1998, this model allows the user to learn through repetition (Finlay, 2008). This model is commonly used in nursing practice which offers basic questions to aid the structure of reflection (Finlay, 2008) therefore this is an appropriate and relevant model of reflection for the proposed incident. Zeichner and Liston (1996) have argued that reflection should examine a broader range of areas of practice such as change implementation. However this is a recommendation for teachers, therefore I feel that Gibbs' model is appropriate for my personal reflection at this stage in my training. To increase the relevance of the structure of my reflection in accordance with the critical

incident, I shall also be applying the four ethical principles; respect for autonomy, beneficence, non maleficence and justice (Beauchamp and Childress, 2001) alongside Gibbs' model to focus the analysis section of the reflection further on the ethical issues.

The significant incident which I have chosen to discuss occurred during a clinical practice placement in a large teaching hospital in the North of England. The patient, Sarah Smith (pseudonym) was a 21 year old female admitted to the ward from the emergency department due to a port a cath (implantable venous access system) infection, which had caused septicaemia. On admission to the ward and review from the medical team it was made apparent that Sarah needed to have the port a cath removed as this was the site of infection, however Sarah was unhappy with this and refused to proceed with the removal unless another was inserted straight away. The doctors explained that this was not possible as the treatment includes parenteral antibiotics for 7-14 days and replacement of the catheter at a separate site after 24-72 hours to avoid reinfection (Holzheimer and Mannick, 2001). Sarah became increasingly distressed, continued to refuse to consent to have the port a cath removed, and stated that she wanted to self discharge the following day despite being increasingly unwell due to septicaemia. (See Appendix B for further information).

During my training I have experienced a small number of patients who have refused to consent to treatment, contributing factors were commonly; affects of alcohol or drugs, severe dementia, or mental illness. However I had never experienced a patient who refused treatment that could potentially result in life threatening effects, with full mental capacity. I felt a mixture of confusion and frustration, and I found it difficult to understand why the patient would not want to comply with treatment that could prevent her from becoming seriously ill. I found it difficult to empathise where previously I had been able to understand the contributing factors for why somebody may be non compliant.

I found this to be a challenging situation and felt very unsure of how to proceed with communication with the patient, for example I did not know whether I should attempt to encourage the patient to comply and consent to the treatment. In reaction to these feelings I found myself avoiding the patient as I did not know how to approach the

situation and felt very unprepared. I realized I did not have the competency to handle a conversation of this nature, and thought that it would be better for more qualified professionals to handle, being unsure of my role. I noted the way my colleagues reacted to this patient, for example during handover she was labelled as 'difficult' and they did not seem concerned when she signed the documentation for self discharge against medical advice. They appeared to not show any emotions towards the patient whereas I felt concerned and worried for the outcome, and wondered what would happen if her health declined further.

The following stage of Gibbs' reflective cycle (1988) asks the author to evaluate what went well, and what went badly in the chosen incident. The aspects of care that I thought were carried out well in this scenario include that all healthcare professionals acted professionally towards the patient, although it was apparent that some of my colleagues had described certain negative feelings towards the incident their reactions to their feelings were never shown to the patient. This made me realize that it is good to acknowledge my feelings however it is important to not present these in front of the patient to ensure you act professionally at all times, keeping in line with the Nursing and Midwifery (NMC) code of conduct (2015) which describes standards for good practice which relating to this incident may include; avoiding making assumptions, recognising individual choice, and respecting an individual's right to refuse treatment. I also found that the healthcare professionals caring for this patient were understanding of her needs and made sure to give her all the information required to make an informed decision, whether or not this was to refuse or accept the treatment.

Following the next stage of Gibb's reflective cycle (1988) I will be analysing the critical incident in consideration of the relevant professional, ethical and legal issues. As previously stated I shall be analysing this scenario alongside Beauchamp and Childress' (2001) ethical principles.

Professional issues which may relate to my chosen incident include analysing the scenario against the professional standards as set by the NMC (2015) which include avoiding making assumptions, respecting and supporting an individual's right to refuse care and ensuring you do not express your own beliefs in an inappropriate manner. The

NMC (2015) also state that you must gain informed consent before carrying out any intervention. All individuals have the right to refuse treatment, as the law recognises that adults have the right to decide what can or cannot be done to their body (Butler-Sloss, 1997). It is therefore a fundamental aspect of nursing practice that consent is sought before carrying out any intervention (Department of health, 2009). Consent can be defined as the patient being properly informed of exactly what is going to happen and any risks involved, they must be fully mentally competent, and must be consenting freely, under no external influence, coercion or threat (Wheeler, 2012). Griffith (2014) also stated that consent is an ongoing process, and it is important to remember that consent can be withdrawn at any given moment. They also state that this is well within the rights of the individual, and this must be respected by any healthcare professional.

I felt as though some healthcare professionals involved in this scenario acted unprofessionally for example when the patient was handed over as being 'difficult', this also goes against the fundamental principles of the code of conduct (NMC, 2015) and as discussed previously, all patients have the right to refuse treatment, and should not have any negativity associated with the choice to do so. I believe is perfectly acceptable to acknowledge thoughts that we as nurses may have, however this shows that it is important to not voice these in an unprofessional manner.

Mazotas et al (2013) offer some advice for caring for patients who are refusing treatment. They suggest that an ethics consultation may be beneficial in cases where the patient and physician are not agreeing on treatment, they also suggest that in the majority of cases personal factors cause the decision to refuse treatment. Ethics consultations may therefore help facilitate discussion of issues such as these, alongside any misunderstandings, questions and implications of refusal of treatment all keeping in mind the potential emotional distress of the patient. This may then hopefully result in a treatment plan both parties can agree to, and be happy with (Arnold et al, 2007). This did not occur in my practice scenario, however I feel as though this would have been highly beneficial for the patient as it may have dispelled any misconceptions or fears towards the procedure, and may have reduced a delay in receiving the treatment.

Analysing this incident further from an ethical perspective, there are key theories which may offer explanation for certain decision making practices in healthcare. Bingham (2012) state that consequentialism for example, is a theory whereby the consequences of actions are examined and focused on to identify which course of action to take, and that this theory may offer justification for overriding a person's decision to refuse treatment, as the outcome of this could bring about serious health complications or even death. On the other hand Bingham (2012) also state that deontology theory focuses on the idea that acts may be right or wrong independently of the outcome, this theory suggests that actions should then be based on your obligations or duty as a healthcare professional. They conclude that consequentialism therefore directly contradicts deontology theory, which proposes that it would be wrong to ignore an individual's right to decide what is done to their own body which presents a conflict in ideas and makes it confusing to determine which theory to apply to practice. Edwards (2009) addresses this conflict by suggesting that aspects from both theories should be applied to practice, in order to reach a solution that both respects the autonomy and well-being of the patient and avoids harm.

Shea (1996) suggested that one of the responsibilities of the nurse in this ethical dilemma is advocacy. This is a further core concept of nursing reinforced by The Code of Conduct (NMC, 2015). Spence (2011) stated that to advocate for your patient means to support and defend an individual's rights and, at times, argue on behalf of them. They state that this may also include acting on behalf of the patient in mind of their best interests and to protect patients who are unable to communicate their own wishes. To understand advocacy we must also understand the concept of autonomy. Autonomy is another of Beauchamp and Childress' (2001) ethical principles which we base our healthcare practice on. Cole et al (2014) state that by supporting patients to be autonomous we must advocate for them. Nurses therefore have an ethical obligation to advocate for their patients to support them with decision making to enable the best possible outcome for their health and overall, autonomy (Davis, 2003). I believe the patient was advocated for in this scenario, as she was given all of the relevant information to make her own decision as her mental capacity allowed her to make her own decisions. Her case was also referred to the medical team to give her further expert information to enable her to make an informed decision.

The professional and ethical issues of consent also correspond with legal issues involved in the scenario I have chosen from practice, which in turn links in with the justice section of Beauchamp and Childress' ethical principles (2001). The law holds the principles of consent in high regard as according to 'common law' under national legislation, touching a patient without consent may result in said person being charged with the criminal offence of battery (Wheeler, 2012). Healthcare professionals must also ensure that they are working in line with the Human Rights Act (1998) as it has been argued that the right to refuse treatment is in concordance with Article (8) - the right to respect for an individual's private life, which describes the individual's rights of self determination and autonomy if they are mentally competent (Samanta, 2005). To apply this to a medical context, this could be understood as the individual's right to 'bodily integrity' which encompases the right to refusal of treatment (Bingham, 2012). This highlights the importance of individual choice and that promoting individual choice should be a high priority for healthcare professionals such as nurses. Therefore, even though serious consequences may potentially occur as a result of refusal of treatment, as described in my patient case study, it is imperative that nurses do not express their views inappropriately in an attempt to coerce, as this does not respect the rights of the individual, and is acting in a paternalistic manner (Griffith, 2015). Paternalism is defined as overriding an individual's autonomy because you believe it is in their best interests. This is not acceptable practice when caring for an individual with full mental capacity to make their own decisions regarding their care (Hendrick, 2004). Adults with full mental capacity have every right to refuse treatment should they so wish, and this must be respected by the multidisciplinary team (Department of Health, 2009). In this aspect I believe the healthcare professionals acted within the ethical and lawful principles in respecting her choice to refuse treatment and not attempt to coerce the patient into making a decision she was unhappy with, in place of this she was given sufficient information to make her own choices.

As previously stated, individuals must have full mental capacity to be able to give consent to treatment. Capacity, under The Mental Capacity Act (2005), is underpinned by five principles. These state that individuals have the right to make their own decisions even if they seem unwise, and that it must be presumed to have capacity

unless explicitly stated otherwise. People must also be supported to make decisions by being given sufficient information to do so. In the case of an individual being deemed not to have mental capacity, any acts done on behalf of this person must be in their own best interests and be as unrestricted of their human rights as possible (Department of Constitutions, 2007). As the patient involved in this scenario was deemed to have full mental capacity, it is made clear by the law and good practice standards set as guidance for nursing, that Sarah was well within her rights to refuse treatment and that her decision to do so should have been respected by all healthcare professionals involved in her care. However, if the patient involved was deemed not to have mental capacity, the multidisciplinary team would therefore be able to act in the patient's best interests and proceed with the treatment.

Accountability is said to be a fundamental aspect of nursing which has been defined by Lewis and Batey (1982) as a formal obligation to carry out certain actions within one's own power, which you are then responsible, and may be answerable to a higher authority for. For nurses this means working in line with the professional standards set out by the Nursing and Midwifery Council (2015), and to be able to justify that your actions were for the benefit of the individuals in your care. Griffith, Richard and Tengnah (2014) stated that the nature of the nurse-patient relationship results in a duty of care, this is so that nurses ensure no harm comes to the patient, to fail to do so would result in negligence of the individual in your care. They also stated that negligence is a legal offence that may be defined as actionable harm, a claim that may come about due to the careless actions of another. This directly relates to Beauchamp and Childress' ethical principle of nonmaleficence, represented by the phrase *primum non nocere* - first do no harm (Lawrence, 2007). Krautscheid (2013) state that accountability is a skill expected at entry level for newly qualified nurses. It has been argued, however, that many new nurses are unable to demonstrate this core skill (Dyess and Sherman, 2009). This suggests that further training and learning opportunities may be required to better prepare newly qualified nurses for the practice of accountability due to the level of it's importance. Accountability therefore has been highlighted as a core concept of nursing, if a clinician fails to carry out their duty of care to their patient, this may result in negligence, an unlawful and unethical act, and the clinician must then be accountable for said actions.

The final ethical principle which arose from my reflection process is the concept of emotional labour in nursing. Henderson (2001) suggests that some nurses may have a tendency to emotionally detach from some scenarios in practice, and that this may be a coping mechanism that they have developed as response to the emotional labour of the nature of nursing as a career. This may offer some explanation for the reason I perceived some nurses not to express emotion towards the patient in this scenario. A paper by Firth-Cozens and Cornwell (2009) offers some reasons for the cause of burnout such as lack of compassion towards oneself leading to lack of compassion towards patients (Gilbert, 2009), making errors in practice leading to self criticism and from this, criticism and lowered empathy towards others (West et al, 2006). It has also been suggested that suppressing feelings to appear more positive outwardly due to feeling expected to act a certain way may lead to becoming emotionally detached (Brotheridge and Grandey, 2002). It is therefore of high importance that healthcare staff feel supported and that there are strategies in place to reduce compassion fatigue. Stewart and Terry (2014) suggest strategies such as clinical supervision and psychological intervention training alongside supportive relationships to manage stress.

In conclusion, by reflecting on a relevant incident from clinical practice I have been able to reflect on my feelings associated with the incident, evaluate what happened and analyse the situation using relevant theory to support my ideas. I believe that this has helped me learn strategies that will help me face similar situations in the future. From this reflection I have learnt that respect for an individual's autonomy is of the utmost importance, and that patients with full mental capacity have the full right to refuse treatment should they so wish, and that in this case healthcare professionals must do all in their power to support this individual through that decision by, for example giving them sufficient information to make an informed decision. This learning has informed my future practice in preparation for being a registered nurse and has given me insight in how to act in the future if I am faced with similar scenarios. This includes acting in a professional manner at all times in line with the standards set out by the NMC (2015) advocating for my patients unabling them to be as autonomous as possible, considering interventions such as ethical consultations to allow patient and clinicians to come to an agreement where both parties are happy with the outcome, and remembering to be

aware of my own well being and addressing my emotions by reflecting on practice to prevent compassion fatigue.

Bibliography:

Arnold. R, Aulisio. M, Begler. A (2007) A commentary on Caplan and Bergman: ethics mediation - questions for the future. *Journal of Clinical Ethics*. 18: 350–354

Beauchamp TL, Childress JF (2001) *Principles of biomedical ethics*, 5th ed. New York City, NY: Oxford University Press

Bingham, S (2012) Refusal of treatment and decision-making capacity. *Nursing Ethics*. [Online] Available at: <http://eds.b.ebscohost.com/eds/pdfviewer/pdfviewer?sid=44917a84-3825-4e17-a38e-faea9b480d9c%40sessionmgr114&vid=0&hid=113>

Brotheridge. C, Grandey. A (2002). 'Emotional labor and burnout: Comparing two perspectives on "people work"'. *Journal of Vocational Behaviour*. [Online] Available at: <http://citeseerx.ist.psu.edu/viewdoc/download?doi=10.1.1.476.6802&rep=rep1&type=pdf>

Butler-Sloss. E (1997) *Re MB (Caesarean Section)* 2 F.L.R. 426. Cited in: Griffith, R (2015) *Patient's who demand or refuse treatment*. British Journal of Cardiac Nursing. [Online] Available at: <http://eds.b.ebscohost.com/eds/pdfviewer/pdfviewer?sid=96e77a63-6e28-4b27-b203-02e8ec6943a7%40sessionmgr114&vid=0&hid=112>

Cole, C. Wellard. S, Mummery. J (2014) Problematising autonomy and advocacy in nursing. *Nursing Ethics*. [Online]. Available at: <http://eds.b.ebscohost.com/eds/pdfviewer/pdfviewer?sid=518bc744-15d2-46f4-9d20-5dc15d9f9304%40sessionmgr110&vid=0&hid=113>

Davis. A, Konishi. E. Tarisho. M (2003) A pilot study of selected Japanese nurses' ideas on patient advocacy. *Nurse Ethics*. [Online]. Available from: <http://nej.sagepub.com/content/10/4/404.long>

Davies, S. (2012) Embracing reflective practice. *Education for Primary Care* [Online], 23, pp. 9-12. Available from: <http://www.ebsco.com/> [Accessed 25 April 2013].

Department of Constitutional Affairs (2007) *Mental Capacity Act 2005: Code of Practice*. London: TSO. [Online]. Available at: <https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/497253/Mental-capacity-act-code-of-practice.pdf>

Department of Health (2009) *Reference guide to consent for examination or treatment.* 2nd ed. [Online]. Available at: <https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/138296/dh_103653__1_.pdf>

Dyess. S, and Sherman. R (2009) The First Year of Practice: New Graduate Nurses' Transition and Learning Needs. *Journal of Continuing Education in Nursing*. [Online]. Available at: <http://www.healio.com/nursing/journals/jcen/2009-9-40-9/%7Ba75d3568-be49-4e27-834c-25726df0706e%7D/the-first-year-of-practice-new-graduate-nurses-transition-and-learning-needs>

Edwards S (2009)*Nursing ethics: a principle-based approach*, second edition. Basingstoke: Palgrave Macmillan

Firth-Cozens. J, Cornwell. J (2009) The Point of Care. Enabling Compassionate Care in Acute Hospital Settings. *The King's Fund*. [Online]. Available at: <http://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/poc-enabling-compassionate-care-hospital-settings-apr09.pdf>

Finlay, L (2008) *Reflecting on 'Reflective Practice'. A dicsussion paper prepared for PBPL CETL* (www.open.ac.uk/pbpl). [Online] Available from: <http://www.open.ac.uk/opencetl/files/opencetl/file/ecms/web-content/Finlay-(2008)-Reflecting-on-reflective-practice-PBPL-paper-52.pdf>

Gibbs G (1998) *Learning by Doing: A guide to teaching and learning methods***.** Further Education Unit. Oxford Polytechnic: Oxford.

Gilbert P (2009). *The Compassionate Mind: A new approach to life's challenges.* London: Constable and Robinson.

Griffith, Richard and Tengnah (2014) *Law and Professional Issues in Nursing, 3rd edition*. Learning Matters/Sage.

Griffith, R (2014) The basic principles of consent. *British Journal of Cardiac Nursing*. [Online]. Available at: <http://www.magonlinelibrary.com/doi/10.12968/bjca.2014.9.6.307>

Griffith, R (2015) *Patient's who demand or refuse treatment. British Journal of Cardiac Nursing***.** [Online] Available at: <http://eds.b.ebscohost.com/eds/pdfviewer/pdfviewer?sid=96e77a63-6e28-4b27-b203-02e8ec6943a7%40sessionmgr114&vid=0&hid=112>

Henderson, A (2001) Emotional labour and nursing: an under-appreciated aspect of caring work. *Nursing Inquiry*. [Online]. Available at:

<https://my.leedsbeckett.ac.uk/bbcswebdav/pid-1002722-dt-content-rid-2893540_1/courses/17994-1516/henderson%202001%20Emoitonal%20labor%20and%20nursing.pdf>

Hendrick, J (2004) *Law and ethics. Foundations in Nursing and Healthcare.* Cheltenham: Nelson Thornes Ltd.

Holzheimer RG, Mannick JA (2001) *Surgical Treatment: Evidence-Based and problem orientated*. Munich: Zuckschwerdt. **Cited in**: Bullard. K. M, Lunn. D. L (2001) *Bloodstream and intravascular catheter infections.* [Online]. Available at: <http://www.ncbi.nlm.nih.gov/books/NBK7008/>

Krautscheid, L (2013) Defining professional nursing accountability: A literature review. *Journal of Professional Nursing*. [Online]. Available at: <http://www.sciencedirect.com/science/article/pii/S8755722313000860>

Lawrence, D (2007) The Four Principles of Biomedical Ethics: A Foundation for Current Bioethical Debate. *Journal of Chiropractic Humanities*. [Online]. Available at: <https://my.leedsbeckett.ac.uk/bbcswebdav/pid-1002658-dt-content-rid-2893318_1/courses/17994-1516/4%20prinicples%20of%20biomedical%20ethics%281%29.pdf>

Lewis, F. & Batey, M.V. (1982) 'Clarifying autonomy and accountability in nursing services', Part 2. *Journal of Nursing Administration*, 12 (10), 10–15

Mazotas. I, McKneally. M, Wall. A, Kodner. I, Keune. J (2013) When a patient refuses treatment for a postoperative complications: the ethics of postoperative care. *Surgery*. [Online]. Available at: <http://www.surgjournal.com/article/S0039-6060(13)00459-5/abstract>

Mental Capacity Act (2005) (c.9) London: HMSO

Nursing and midwifery council (NMC) (2015) *The code: professional standards of practice and behaviour for nurses and midwives*. London: NMC

Rees. C.E, Monrouxe. L.V, and McDonald. L.A (2015) 'My mentor kicked a dying woman's bed. . .' Analysing UK nursing students' 'most memorable' professionalism dilemmas. *Journal of Advanced Nursing.* 71(1), 169–180

Samata. A, Samanta J (2005) The Human Rights Act 1998 - why should it matter for medical practice? *Journal of the Royal Society of Medicine*. [Online]. Available at: <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1199635/>

Schon, D. (1983) *The reflective practitioner*. San Francisco: Jossey-Bass.

Shea, M (1996) 'Legally speaking. When a patient refuses treatment', *RN*. [Online]. Available at: <http://eds.a.ebscohost.com/eds/pdfviewer/pdfviewer?sid=cd122642-9a37-4939-920a-0dc7c5a00095%40sessionmgr4004&vid=0&hid=4102>

Spence K (2011) Ethical advocacy based on caring: a model for neonatal and paediatric nurses. *Journal of Paediatric Child Health*. [Online]. Available at: <http://onlinelibrary.wiley.com/doi/10.1111/j.1440-1754.2011.02178.x/epdf>

Stewart. W, Terry. L (2014) Reducing burnout in nurses and care workers in secure settings. *Nursing Standard*. [Online]. Available at: <http://eds.a.ebscohost.com/eds/pdfviewer/pdfviewer?sid=4257392c-1e54-4542-88a5-0d4a4f89ab88%40sessionmgr4001&vid=0&hid=4102>

The Human Rights Act (1998) London: Stationery Office

Wheeler, H. (2012) *Law, ethics, and professional issues for nursing*. Abingdon, Oxon, Routledge.

West CP, Huschka MM, Novotny PJ, Sloan JA Kolars JC, Habermann TM, Shanafelt TD (2006).'Association of perceived medical errors with resident distress and empathy: a prospective longitudinal study'. *Journal of the American Medical Association* [Online]. Available at: <http://jama.jamanetwork.com/article.aspx?articleid=203249>

Zeichner, K. M. and Liston, D. P. (1996) *Reflective Teaching: An Introduction.* Lawrence Erlbaum. Associates Publishers.

Appendices:

A. Gibb's Reflective Cycle (Gibbs, 1998)

Appendix B: Patient history

Following a conversation with Sarah it was discovered that she had a previous traumatic experience whereby her port a cath needed to be removed and couldn't be replaced straight away. During this time instead of medication being inserted through the venous access port, it was injected into bone and Sarah expressed that this was very painful. This therefore would be contributing factors towards Sarah's decision to refuse treatment.